

# DWC 23<sup>rd</sup> Annual Educational Conference: Utilization Review (UR) and Independent Medical Review (IMR)

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## Utilization Review Overview

- Physicians submit Request for Authorization
- Primary and Secondary Treating Physicians
- Claims administrators approve treatments
- Cases that not approved must be reviewed by a physician who uses medical evidence to
  - Approve treatment or
  - Deny treatment
- Response in five working days

## Utilization Review/ RFA Form

- Mandatory use of the Request for Authorization Form (DWC Form RFA-1) or accepted alternate.
- RFA must (1) identify the employee and the provider,(2) specify the recommended treatment, and (3) include documentation showing the medical necessity of the treatment.
- The claims administrator may accept an alternate RFA:
  - “Request for Authorization” must be clearly written at the top of the first page.
  - All requested treatment must be on the first page.
  - The request is accompanied by supporting documentation.

State of California, Division of Workers' Compensation  
REQUEST FOR AUTHORIZATION  
DWC Form RFA

Attach the Doctor's First Report of Occupational Injury or Illness, Form DLSR 5021, a Treating Physician's Progress Report, DWC Form PR-2, or equivalent narrative report substantiating the requested treatment.

New Request
  Expedited Review: Check box if employee faces an imminent and serious threat to his or her health. Check box if request is a written confirmation of a prior oral request.
  Resubmission - Change in Material Facts

**Employee Information**

Name (Last, First, Middle): \_\_\_\_\_ Date of Birth (MMDD/YYYY): \_\_\_\_\_  
 Date of Injury (MMDD/YYYY): \_\_\_\_\_ Employer: \_\_\_\_\_  
 Claim Number: \_\_\_\_\_

**Requesting Physician Information**

Name: \_\_\_\_\_  
 Practice Name: \_\_\_\_\_ Contact Name: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_  
 Zip Code: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax Number: \_\_\_\_\_  
 Specialty: \_\_\_\_\_ NPI Number: \_\_\_\_\_  
 E-mail Address: \_\_\_\_\_

**Claims Administrator Information**

Company Name: \_\_\_\_\_ Contact Name: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_  
 Zip Code: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax Number: \_\_\_\_\_  
 E-mail Address: \_\_\_\_\_

**Requested Treatment (see instructions for guidance; attached additional pages if necessary)**

List each specific requested medical services, goods, or items in the below space or indicate the specific page number(s) of the attached medical report on which the requested treatment can be found. Up to five (5) procedures may be entered; list additional requests on a separate sheet if the space below is insufficient.

Diagnosis (Required)	ICD-Code (Required)	Service/Good Requested (Required)	CPT/HCPCS Code (If known)	Other Information: (Frequency, Duration Quantity, etc.)

Requesting Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Claims Administrator/Utilization Review Organization (URO) Response**

Approved
  Denied or Modified (See separate decision letter)
  Delay (See separate notification of delay)
  Requested treatment has been previously denied
  Liability for treatment is disputed (See separate letter)

Authorization Number (if assigned): \_\_\_\_\_ Date: \_\_\_\_\_  
 Authorized Agent Name: \_\_\_\_\_ Signature: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Fax Number: \_\_\_\_\_ E-mail Address: \_\_\_\_\_  
 Comments: \_\_\_\_\_

State of California, Division of Workers' Compensation TREATING PHYSICIAN'S REPORT (DWC Form PR-2)				
<b>Check all applicable boxes:</b>				
<input type="checkbox"/> Request for Authorization	<input type="checkbox"/> Change in Work Status	<input type="checkbox"/> Released From Care		
<input type="checkbox"/> Periodic Report	<input type="checkbox"/> Change in Patient's Condition	<input type="checkbox"/> Transfer of Care		
<input type="checkbox"/> Response to Request for Information	<input type="checkbox"/> Change in Treatment Plan	<input type="checkbox"/> Other		
<b>1. Patient Information</b>				
Name (Last, First, Middle):				
Date of Injury (MM/DD/YYYY):		Date of Birth (MM/DD/YYYY):		
Claim Number:		Employer:		
<b>2. Physician Information</b>				
Name:				
Practice Name:		Contact Name:		
Address:		City:	State:	
Zip Code:	Phone:	Fax Number:		
Specialty:	NPI Number:			
E-mail Address:				
<b>3. Claims Administrator Information</b>				
Company Name:		Contact Name:		
Address:		City:	State:	
Zip Code:	Phone:	Fax Number:		
E-mail Address:				
<b>4. Request for Authorization (if required; attached additional pages if necessary)</b>				
List each specific requested medical service, goods, or items in the below space or indicate the specific page number(s) of the attached medical report on which the requested treatment can be found. Up to five (5) procedures may be entered; list additional requests on a separate sheet if the space below is insufficient. For surgery requests, include full surgery orders (pre and post-op, if known). If request is to continue therapy, attach documentation of functional improvement.				
Diagnosis (Required)	ICD-Code (Required)	Service/Good Requested (Required)	CPT/HCPCS Code (If known)	Other Information: (Frequency, Duration Quantity, etc.)
Is treatment consistent with Medical Treatment Utilization Schedule (MTUS)?				
<input type="checkbox"/> Yes, Applicable MTUS Guidelines:				
<input type="checkbox"/> No. Explain reason for variance from MTUS (attached documentation substantiating request):				
<b>5. Signature and Included Sections</b>				
<input type="checkbox"/> Section A: Evaluation and Management Worksheet				
<input type="checkbox"/> Section B: Work Status				
I declare under penalty of perjury that this report is true and correct to the best of my knowledge and that I have not violated Labor Code section 139.3.				
Physician Signature:				Date:
Executed at:				

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Treating Physician's Report (DWC Form PR-2)	Patient Name:
Page 2	
<b>SECTION A: Evaluation and Management Worksheet - Contains Private Healthcare Information</b>	
<b>1. Chief Complaint(s) and Interval History (include subjective complaints):</b>	
<b>2. Physical Examination (objective findings):</b>	
<b>3. Other Information Reviewed (includes consultations, records, laboratory, radiology, and diagnostic testing):</b>	
<b>4. Assessment/Diagnosis (include co-morbidities and complications; use additional pages if necessary):</b>	
Primary Diagnosis:	ICD-10:
Secondary Diagnosis:	ICD-10:
Additional Diagnosis:	ICD-10:
Additional Diagnosis:	ICD-10:
Additional Diagnosis:	ICD-10:
Additional Diagnosis:	ICD-10:
<b>5. Discussion (indicate assessment):</b>	
<b>6. Secondary Physician Reports (if applicable; discuss and, if appropriate, incorporate findings):</b>	
<b>7. Treatment Plan:</b>	
If physician is requesting authorization for treatment, complete Request for Authorization section on Page 1, indicating the treatment(s), reference to treatment guidelines, and explanation if the treatment is at variance with the MTUS. Indicate whether any prescription for medication or supplies must be dispensed as written.	
<input type="checkbox"/> Continue same treatment plan (see prior reports)	<input type="checkbox"/> Discharge from care
<input type="checkbox"/> Change in treatment plan - see Request for Authorization	<input type="checkbox"/> Dispense prescription as written

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Treating Physician's Report (DWC Form PR-2)		Patient Name:	
Page 3			
<b>SECTION B: Work Status</b>			
Employers may only receive Section B (Work Status) as other sections contain private healthcare information.			
1. Patient has been instructed to:			
<input type="checkbox"/> Return to full duty without restrictions.		Date:	
<input type="checkbox"/> Return to work with the following work restrictions (list all specific, functional restrictions, i.e., standing, sitting, bending, lifting, etc.):		How long will the work restrictions apply? <input type="checkbox"/> 1-2 days <input type="checkbox"/> 3-7 days <input type="checkbox"/> 8-14 days <input type="checkbox"/> 15+ days <input type="checkbox"/> Unknown at this time	
<input type="checkbox"/> Patient is unable to return to work in any capacity for the indicated period. State reason:		Date: _____ to _____ Date: _____	
<b>2. Patient Status:</b>			
<input type="checkbox"/> Anticipate date of return to full duty with no limitations or restrictions.		Date: _____	
<input type="checkbox"/> Anticipate date of maximum medical improvement and permanent work restrictions (if applicable).		Date: _____	
<input type="checkbox"/> Date of next visit.		Date: _____	
<input type="checkbox"/> Date discharged from care.		Date: _____	

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## RFA Tips

- Use evidence-based medicine for treatment course
- Follow the MTUS guidelines
- Complete the RFA or an accepted equivalent
- Provide full explanation for requested treatments
- Submit literature-based evidence to justify recommendations if going outside MTUS
  - Note new strength of evidence rules (8 C.C.R. section 9792.21.1)
- Be available for peer to peer UR discussions

## Utilization Review – Timely?

Dubon v. World Restoration, Inc. (2014) 79 Cal. Comp. Cases 1298 (en banc) (Dubon II):

- A UR decision is invalid and not subject to IMR only if it is untimely.
- With the exception of timeliness, all other UR requirements go to the validity of the medical decision or decision-making process.
- The sufficiency of the medical records provided, expertise of the reviewing physician and compliance with the MTUS are questions for IMR.
- For an untimely UR decision, medical necessity is based on on substantial medical evidence consistent with Labor Code Section 4604.5.

## UR Timelines

- Decision within 5 working days after receipt of RFA
- Notify within 24 hours, written decision within 2 working days (prospective/concurrent)
- Expedited review – 72 hours
- Retrospective review – 30 days
- Extension for additional information
  - Decision in 14 days
  - Decision in 30 days for additional test or specialized consultation
- Untimely decision – Dubon II & Sandhagan

## UR Liability Disputes

- A factual, medical, or legal basis exists, other than medical necessity, that precludes compensability.
  - Denied claim
  - Denied body part
  - Legal reason (24 visit cap)
  - IMR
  - Labor Code section 5402(c) - \$10K cap on medical treatment until claim accepted or rejected.
- Deferral of UR – section 9792.9.1(b)

## UR Internal Appeal

- Process explained in UR decision letter
- Runs concurrent with IMR
- Timeframe:
  - Request by employee within 10 days following UR decision.
  - Completed 30 days after receipt of request.
- IMR Application?
  - Modification of decision only
  - Checkbox on IMR Application

## Independent Medical Review (IMR)

- Replaces QME procedure
- Medical expertise to resolve treatment disputes to provide timely, appropriate care for injured workers
- IMR contractor is Maximus Federal Services
- Not the Medical Provider Network IMR program

## IMR Fees

Costs paid by the employer/claims administrator

- Standard IMRs Involving Non-Pharmacy Claims
  - \$390 per IMR
- Standard IMRs Involving Pharmacy Only Claims
  - \$345 per IMR
- IMRs Terminated or Dismissed Not Forwarded to a Medical Professional Reviewer:
  - \$123 per IMR

## IMR Process

- Requested by injured worker/designee
  - 30 days from issuance of UR determination
- Complete IMR application requires:
  - Signed, completed IMR Form
  - Authorized Representative?
  - Copy of UR determination letter
  - Copy of application sent to claims administrator
- IMR may be terminated at any time if treatment is approved

State of California, Division of Workers' Compensation  
APPLICATION FOR INDEPENDENT MEDICAL REVIEW  
DWC Form IMR

**TO REQUEST INDEPENDENT MEDICAL REVIEW:**

1. Sign and date this application and consent to obtain medical records.
2. Mail or fax the application and a copy of the written decision you received that denied or modified the medical treatment requested by your physician to:  
DWC-IMR, c/o Maximus Federal Services, Inc., P.O. Box 138009, Sacramento, CA 95813-8009  
FAX Number: (916) 606-4270
3. Mail or fax a copy of the signed application to your Claims Administrator.

Type of Utilization Review: <input type="checkbox"/> Regular <input type="checkbox"/> Expedited		Modification after Appeal <input type="checkbox"/>
<b>Employee Name (First, MI, Last):</b>		
Address:		
Phone Number:	Employer Name:	
Claim Number:	Date of Injury (MM/DD/YYYY):	
WCIS Jurisdictional Claim Number (if assigned):	EAMS Case Number (if applicable):	
Employee Attorney (if known):		
Address:		
Phone Number:	Fax Number:	
<b>Requesting Physician Name (First, MI, Last):</b>		
Practice Name:		Specialty:
Address:		
Phone Number:	Fax Number:	
<b>Claims Administrator Name:</b>		
Adjuster/Contact Name:		
Address:		
Phone Number:	Fax Number:	
<b>Disputed Medical Treatment (complete below section)</b>		
Primary Diagnosis (Use ICD Code where practical):		
Date of Utilization Review Determination Letter:		
Is the Claims Administrator disputing liability for the requested medical treatment besides the question of medical necessity? <input type="checkbox"/> Yes <input type="checkbox"/> No Reason:		
List each specific requested medical services, goods, or items that were denied or modified in the space below. Use additional pages if the space below is insufficient.		
1.		
2.		
3.		
4.		
<b>Request for Review and Consent to Obtain Medical Records</b>		
I request an independent medical review of the above-described requested medical treatment. I certify that I have sent a copy of this application to the claims administrator named above. I allow my health care providers and claims administrator to furnish medical records and information relevant for review of the disputed treatment identified on this form to the independent medical review organization designated by the Administrative Director of the Division of Workers' Compensation. These records may include medical, diagnostic imaging reports, and other records related to my case. These records may also include non-medical records and any other information related to my case, excepting records regarding HIV status, unless infection with or exposure to HIV is claimed as my work injury. My permission will end one year from the date below, except as allowed by law. I can end my permission sooner if I wish.		
Employee Signature:	Date:	

**Authorized Representative Designation for Independent Medical Review**  
(To accompany the Application for Independent Medical Review, DWC Form IMR)

**Section I. To be completed by the Employee:**

Employee Name (Print): \_\_\_\_\_

I wish to designate \_\_\_\_\_

Name of Individual (Print): \_\_\_\_\_

to act on my behalf regarding my Application for Independent Medical Review. I authorize this individual to receive any notice or request in connection with my appeal, and to provide medical records or other information on my behalf. I further authorize the Division of Workers' Compensation, and the Independent Medical Review Organization designated by the Division of Workers' Compensation to review my application, to speak to this individual on my behalf regarding my Application for Independent Medical Review. I understand that I have the right to designate anyone that I wish to be my authorized representative and that I may revoke this designation at any time by notifying the Division of Workers' Compensation or the Independent Medical Review Organization designated by the Division of Workers' Compensation to review my application.

In addition to designating the above-named individual as my authorized representative, I allow my health care providers and claims administrator to furnish medical records and information relevant for review of the disputed treatment to the independent review organization designated by the Administrative Director of the Division of Workers' Compensation. These records may include medical, diagnostic imaging reports, and other records related to my case. These records may also include non-medical records and any other information related to my case. I allow the independent review organization designated by the Administrative Director to review these records and information sent by my claims administrators and treating physicians. My permission will end one year from the date below, except as allowed by law. I can end my permission sooner if I wish.

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Section II. To be completed by the Authorized Representative designated above. Law firms, organizations, and groups may represent the Employee, but an individual must be designated to act on the Employee's behalf.**

I accept the above designation to act as the above-named Employee's authorized representative regarding their Application for Independent Medical Review. I understand that the Employee may revoke this authorization at any time and appoint another individual to be their authorized representative.

Name:	_____	
I am a/an:	_____	
(Professional status or relationship to the Employee, e.g., attorney, relative, etc.)	_____	
Address:	_____	
City:	State:	Zip Code:
Phone Number:	Fax Number:	
State Bar Number (if applicable):	_____	
Representative Signature:	_____	Date:

## Eligibility for IMR

- Initial review of application for eligibility
  - Incomplete application despite attempts to obtain missing documentation
    - Was application signed? UR decision attached?
    - Was the application modified?
  - Liability dispute
  - Timelines not met
  - UR denied due to absent medical records

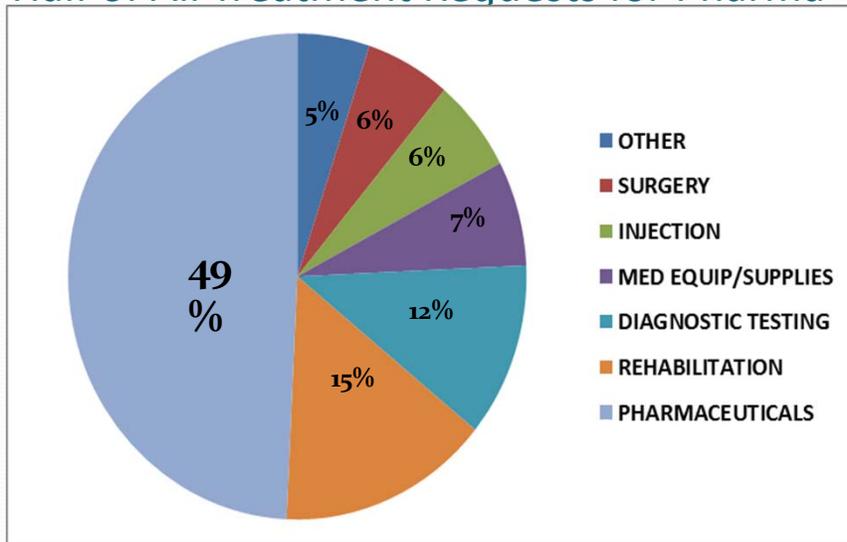
## IMR Determinations

- 30 days from request and receipt of records. Labor Code § 4610.6(d)
- Reviews must include
  - Individual assessment of case
  - Determination on disputed medical treatment
    - Based on specified treatment guidelines
  - Medical qualifications of reviewers
    - License jurisdiction, subspecialty

## IMR Determinations

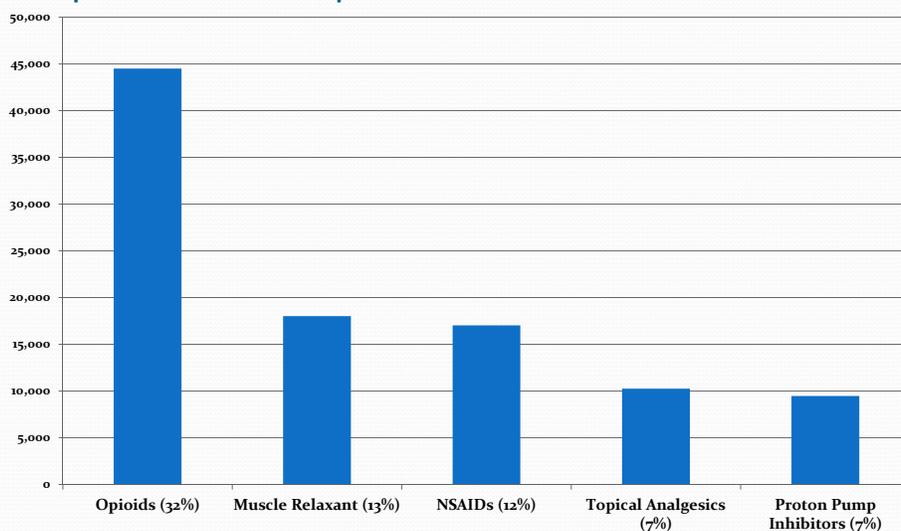
- IMR Determinations available on DWC website
- Automation of the posting process
- [https://www.dir.ca.gov/dwc/IMR/IMR\\_Decisions.asp](https://www.dir.ca.gov/dwc/IMR/IMR_Decisions.asp)

## Half of All Treatment Requests for Pharma



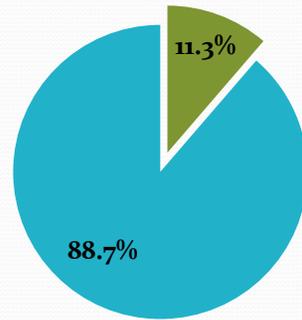
## Most Requested Pharmaceuticals 2015

Top 5 = 71% of all pharmaceutical classifications



## IMR Overturns 1 in 9 UR Denials in 2015

- IMR Cases contain one or more denied treatment requests, averaging 1.9.
- Similar overturn rate as 2014 (between 11% and 12%).



■ OVERTURNED (34,874)  
 ■ UPHELD (274,071)

## Where do the IMRs originate?

Los Angeles	20,200	25%	Contra Costa	3,751	5%
Orange	5,213	6%	Sacramento	3,521	4%
San Bernardino	5,041	6%	Santa Clara	2,687	3%
Riverside	4,587	6%	Ventura	2,398	3%
Alameda	4,097	5%	All Other Counties	25,167	31%
San Diego	3,912	5%	<b>TOTAL</b>	<b>80,574</b>	<b>100%</b>

Based on Injured Worker's County of Residence  
 July to December 2015

## IMR Appeal and Penalties

- Parties have 30 days to appeal IMR Determinations to the WCAB
  - Limited grounds for appeal:
    - AD acted in excess of powers
    - Determination procured by fraud
    - Conflict of interest by reviewer
    - Determination result of bias (race, national origin, religion, age, sex, disability)
    - Determination was the result of a plain error

## IMR Appeals

- 8 C.C.R. section 10957.1 (WCAB Rules)
  - For both eligibility and final determinations
  - Petition in District Office must be filed within 30 days of decision (+5 for mailing)
  - Served on adverse party (and attorney) and DWC Medical Unit
  - DWC Medical Unit download record to EAMS
  - DOR must be filed
- If reversed, case must be remanded to AD for a second IMR determination. Labor Code § 4610.6(i).

## IMR Appeals

- If stipulation, be sure order includes finding under one of the limited grounds of appeal.
- Order must be served on the Medical Unit.

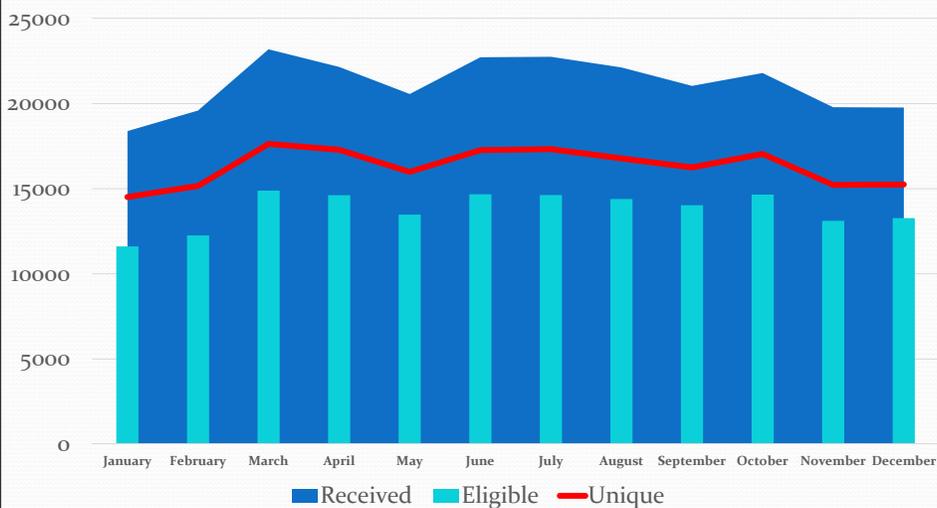
## IMR Penalties

- Administrative Penalties
  - Order to Show Cause by Administrative Director
- IMR Penalties - 8 C.C.R. § 9792.12(c)
  - Failure to include IMR Application in UR decision
  - Failure to advise injured worker of IMR process
  - Failure to provide medical records

## IMR Resource

- Independent Medical Review
  - <http://www.dir.ca.gov/dwc/IMR.htm>
- Frequently Asked Questions
  - [http://www.dir.ca.gov/dwc/IMR/IMR\\_FAQs.htm](http://www.dir.ca.gov/dwc/IMR/IMR_FAQs.htm)
- Regulations
  - [http://www.dir.ca.gov/dwc/DWCPPropRegs/IMR/IMR\\_Regs.htm](http://www.dir.ca.gov/dwc/DWCPPropRegs/IMR/IMR_Regs.htm)
- Forms
  - <http://www.dir.ca.gov/dwc/forms.html>
- DWC Medical Unit
  - <http://www.dir.ca.gov/dwc/MedicalUnit/imchp.html>

## IMR in 2015: Volumes



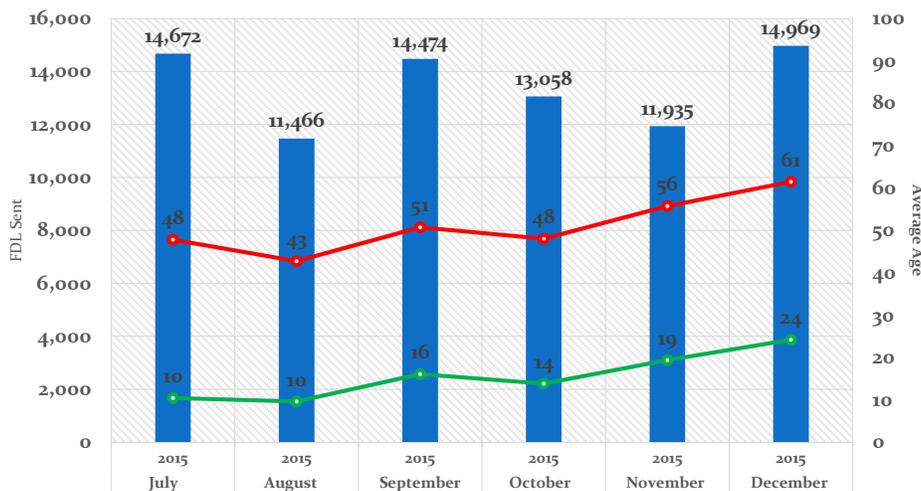
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## IMR in 2015: Ineligible IMRs



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## IMR in 2015: FDLs



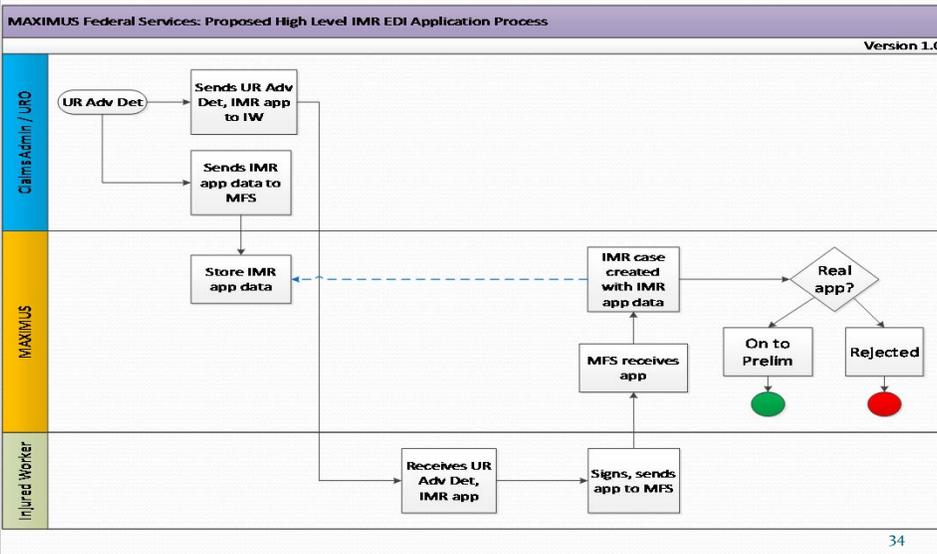
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## IMR Tips

- Injured workers/attorneys:
  - Use the copy of the IMR application provided with the UR letter
  - Provide a complete copy of the UR letter with the signed IMR application
- Claims administrators:
  - Receive NOARFIs/invoices using MOVEit
- All:
  - Use MOVEit (SFTP) to submit documents
  - Contact us with questions about status

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## IMR in 2016: EDI



## EDI: Goals

- Eliminates “rogue” applications
- Attaches unique number to each UR decision
- Provides structured data on claims administrators and UROs
- Sets the table for the IMR Portal / fully electronic processes

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## IMR in 2016: The IMR Portal

Document Exchange - CA DWC IMR Home Cases Documents Administration james.freely@freelance.com Logout

California DWC - IMR Document Exchange Portal

The California Division of Workers' Compensation (DWC) uses a process called independent medical review (IMR) to resolve disputes about the medical treatment of injured employees. This portal supports the IMR process by allowing case participants to upload and view appeal related documents, view case details, and perform other actions related to their role in the process.

 <b>Request for Information</b> See a list of cases that need attention or require documentation.	 <b>Case Search</b> You can search for and see list of cases you have access to. Pick a case from the list to see case details, activities, and view / upload documents.
 <b>Documents</b> You can upload multiple documents as a batch to multiple cases based on a prescribed naming convention.	 <b>Invoicing</b> See monthly invoice summaries by IMR categories. You can also process payment transactions for outstanding balances.

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## The IMR Portal: Goals

- Central hub for all IMR communication
  - Sign and submit applications electronically
  - Check case status
  - Submit documents
  - View documents
  - Electronic correspondence
  - Invoicing

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## How to Contact MAXIMUS

- If you have IMR-related questions or concerns, please contact MAXIMUS Federal Services:
  - By toll-free phone: (855) 865-8873
  - By email: [IMRHelp@maximus.com](mailto:IMRHelp@maximus.com)

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